

**DEPARTMENT OF INSURANCE**

CONSUMER SERVICES AND MARKET CONDUCT BRANCH

CONSUMER SERVICES DIVISION

300 SOUTH SPRING STREET, SOUTH TOWER

LOS ANGELES, CA 90013

[www.insurance.ca.gov](http://www.insurance.ca.gov)

CCB-012 P

Revised: 01/03/2011

**REQUEST FOR ASSISTANCE**

Name \_\_\_\_\_

Work Phone \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

**Before you file a complaint with the Department of Insurance, you should first contact the insurance company, agent or broker in an effort to resolve the issue(s). If you do not receive a satisfactory response, then complete this form, attach copies of any important papers that relate to your complaint and mail to address shown above.**

**Please be aware that a copy of this Request for Assistance and other documentation submitted by you may be provided to the insurance company, agent or broker unless you indicate that you do not want a copy of your correspondence forwarded by checking the box:**

- ☐ **Do not forward a copy** of the completed form and the documentation provided. However, please contact the insurance company and investigate the complaint on my behalf.

1. Complete name of insurance company involved:

\_\_\_\_\_

2. Type of Insurance: Auto ☐ Home ☐ Life ☐ Health ☐ Other ☐ \_\_\_\_\_

3. (a) Name of the policyholder if different from your name:

\_\_\_\_\_

(b) If a group policy, provide the group name:

\_\_\_\_\_

4. Policy identification or certificate number:

\_\_\_\_\_

5. Claim number (if applicable) \_\_\_\_\_

6. Date loss occurred or began (if applicable) \_\_\_\_\_

7. Broker/Agent (if applicable) \_\_\_\_\_ Broker/Agent License number \_\_\_\_\_

Street address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

8. Have you contacted the company, agent or broker? Yes ☐ No ☐

If yes, state the date(s) and person(s) contacted \_\_\_\_\_

(Provide copies of all correspondence)

9. Have you reported this to any other governmental agency? Yes ☐ No ☐

If yes, please give:

(1) Name of agency: \_\_\_\_\_

(2) File number, if known: \_\_\_\_\_

10. Have you previously written to the Department of Insurance about this matter?

Yes ☐ No ☐ File number (if available) \_\_\_\_\_ Date \_\_\_\_\_

11. Is there attorney representation in this matter? Yes ☐ No ☐

12. Is a lawsuit currently on-going or pending? Yes ☐ No ☐ If yes, our ability to mediate this matter is limited, but we will investigate your inquiry for any regulatory issues. We may defer the regulatory investigation until the finality of the litigation. We ask that you still complete this form so we have a record of your issue. Once the matter is concluded, we would welcome any information regarding violations of law by the insurer that you or your attorney are willing to provide.

13. Briefly, describe your problem (use additional paper if needed):

14. What do you consider to be a fair resolution to your problem?

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)